Early and Periodic Screening Diagnosis and Treatment
TRACKING FORM
2-4 DAY

TO BE FILLED IN BY OFFICE STAFF:

Last Name	First Name	AHCCCS ID	D.O.B.	Age

Primary Care Provider	Date of Examination	Health Plan Name

Birth Wt.	Weight	Percentile	Height	Percentile	Head Circumference	Percentile

TO BE FILLED IN BY PROVIDER

INITIAL HISTORY

Was history form completed? [ ] Yes [ ] No
Is a 2nd newborn screening (PKU, etc.) necessary? [ ] Yes [ ] No
Was Hepatitis B given in the hospital? [ ] Yes [ ] No
NUTRITIONAL ASSESSMENT [ ] Breast Feeding [ ] Formula (type) _____
Supplements: [ ] Fluoride [ ] Vitamins [ ] Iron
SENSORY ASSESSMENT Vision: Within normal limits? [ ] Yes [ ] No, Refer
Hearing: Within normal limits? [ ] Yes [ ] No, Refer
DEVELOPMENTAL ASSESSMENT Age appropriate? [ ] Yes [ ] No

PHYSICAL EXAM

Are the following normal?

	Yes	No
Skin		
Head		
Eyes (red reflex)		
Ears		
Nose		
Mouth/Throat		
Nodes		
Heart		
Lungs		
Abdomen (cord)		
Rectum		
Fem. Pulse		
Ext. Gen.		
Hip Abduc.		
Extremities		
Spine		
Neuro		
Other		

COMMENTS, ASSESSMENT & PLAN

Follow-up needed? [ ] Yes [ ] No

IMMUNIZATION ASSESSMENT

Did this child receive all immunizations due today? [ ] Yes [ ] No
Is there a current immunization record in the medical chart? [ ] Yes [ ] No

ANTICIPATORY GUIDANCE

[ ] Good parenting practices
[ ] Postpartum adjustment
[ ] Infant care/sleep positioning
[ ] Injury prevention
[ ] Closeness with the baby
[ ] Individuality of infants
[ ] Breast / Bottle feeding
[ ] Signs of Illness

REFERRALS

[ ] CRS
[ ] WIC
[ ] Specialty _____
[ ] Other

Next scheduled visit	Clinician Name	Clinician Signature

Was this claim coded as an EPSDT Visit (HCFA-1500)? [ ] Yes [ ] No